



# Pediatrics South

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412.561.7541

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3055 Washington Rd.  
Suite 102  
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724.969.5025

## RELEASE OF MEDICAL RECORDS TO PEDIATRICS SOUTH

I hereby authorize:

Doctor/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

To release information from the medical records of:

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

To the following name and address:

**PEDIATRICS SOUTH  
240 MT. LEBANON BLVD.  
PITTSBURGH, PA 15234**

**PHONE: 412.561.7541 FAX: 724.731.0261  
724.731.0262**

Information to be released:

\_\_\_\_\_ Immunization records only

\_\_\_\_\_ Immunization records and last health review

\_\_\_\_\_ All medical records

\_\_\_\_\_ Other (please specify) \_\_\_\_\_

\_\_\_\_\_  
Signature of patient/legal guardian:

\_\_\_\_\_  
Date:

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